# LEAD THE WAY | Transforming America's Health

We envision a nation with an affordable health care system that leaves no one behind. To achieve this vision, we must work with policymakers to realize maximum coverage and deliver high value and clinical excellence across the continuum of care. Maximum coverage requires Medicaid expansion, innovation, and sustainability.
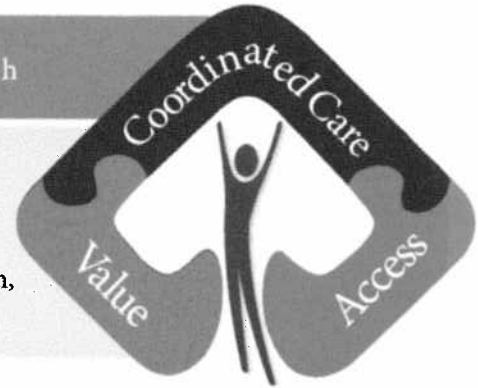
How Is Trinity Health Transforming Health Care Delivery?

Trinity Health is transforming care delivery and maximizing patient access to care by:

▸ Investing in transformative technologies
▸ Deploying system-wide clinical best practices
▸ Leveraging the power of electronic health records and evidence-based medicine

▸ Investing over $600 million in community benefit
▸ Partnering with insurers, employers and leaders

Through partnerships with insurers and employers, our hospitals offer high-value care delivery and stand behind it, putting their reimbursement at risk with performance-based pay agreements. For example, we have the largest value-based reimbursement contract in the state of Michigan. As a result, the interests of physicians, hospitals and post-acute care providers are all aligned to provide optimal care in a highly efficient manner. Through this contract and others like it, Trinity expects to eliminate between $50 million and $80 million in health care costs over the next three years in Michigan alone.

We also work with leaders in each of our 10 states, helping them innovate and improve their states' Medicaid programs. As active purchasers of health care services — at a time when the Department of Health and Human Services is eagerly accepting Medicaid State Plan Amendments and waivers — states are in a great position to replicate innovation from the commercial sector.

To keep Medicaid sustainable with limited resources, states have only two options: lower per capita costs or reduce the number of beneficiaries. Trinity Health believes that states have all-too-often considered only cuts to provider reimbursement to lower per capita costs. Instead, the solution to reducing costs without risking the sustainability and continuing quality of hospital services is to:

1. Actively pursue new payment and delivery models with providers; and
2. Engage beneficiaries in personal responsibility.

KEYS TO CREATING INNOVATIVE MEDICAID PROGRAMS

▸ Redesign payment and delivery models to improve outcomes for Medicaid beneficiaries:
  · Support patient-centered medical homes for coordination of patient care
  · Engage in accountable care organization demonstrations to promote shared savings
  · Create incentives for cost-effective treatment options
  · Integrate care models for dual-eligible populations
  · Implement policies to reduce both adverse events and preventable readmissions

▸ Deploy value-based purchasing and transparency innovations to reward high-quality care:
  · Pay for performance to incentivize quality and patient safety
  · Include quality and safety standards in Medicaid-managed care organization (MCO) contracts
  · Invest in an all-payer claims database to collect and analyze health care data more comprehensively, across payers

▸ Promote beneficiary engagement through consumer incentives and benefit design:
  · Offer tiered premiums or co-payments that promote primary care and reward patient compliance
  · Seek benefit changes and consumer incentives that promote healthy behaviors, wellness, cooperation with treatment plans, and medication compliance
  · Support point-of-care support systems including health coaches, care managers, and behavioral health workers

▸ Offer competitive provider reimbursement to ensure availability of adequate primary care workforce:
  · Support loan repayment programs and graduate medical education

▸ Expand coverage of, and reimbursement for, telehealth services that enhance access, outcomes, and efficiency:
  · Achieve savings derived from telemedicine, remote monitoring, and mobile health applications

How Are Some States Innovating?

Michigan's Medicaid Managed Care Model

- Includes the Medicaid and Children's Health Insurance Program (CHIP) populations as well as the aged, blind and disabled population. In total, covers over 65% of Michigan's Medicaid population and enrolls them into one of the thirteen managed care plans
- Decreases costs: Realized $4.5 billion in total savings between 2000 and 2010 when compared to fee-for-service[i] agreements
- Rewards high-quality plans by auto-assigning a greater number of enrollees into plans with higher quality scores
- Uses external auditors to evaluate plan performance of key measures, including HEDIS

Community Care of North Carolina's (CCNC) Patient Centered Medical Home (PCMH) Model

- As the oldest PCMH program, CCNC includes the CHIP population with the long-term goal of including all NC citizens
- Manages care by providing preventive services and identifying at-risk patients for care management programs
- Targets asthma and diabetes, and has adopted quality measures associated with evidence-based guidelines for diabetes, asthma, heart failure, hypertension, and cardiovascular disease
- Improves quality: Between 2003 and 2006, asthma patients' emergency department inpatient admissions decreased by 40%; diabetes quality measures have improved by 15 percent[ii]
- Decreases costs: Total statewide savings were approximately $382 million in 2010 and expenses between 2003 and 2007 were $574 million less than the projection for a traditional primary care case management program[iii]
- Exchanges data electronically through the state's Informatics Center which houses Medicaid claims data, primary care records for program participants, laboratory results for the Medicaid population, real-time hospital admission/discharge/transfer data from 48 NC hospitals, Medicare, and Surescripts pharmacy data for dual-eligible and other demonstration participants

Oregon's Coordinated Care Model

- Shifts Medicaid beneficiaries, and some other populations into accountable Care Coordination Organization (CCO) models that reward quality outcomes rather than volume
- Aligns incentives across care settings, including primary care, acute care, and long-term care, aiming to reduce spending by 2 percentage points per individual over two years[iv]
- Ensures CCOs are held responsible for achieving high quality outcomes and cost-savings by managing a capitated payment that includes mental, physical and, in future years, dental care for patients
- Decreases costs: The program is expected to save $11B over 10 years[v]
- Shares best practices among CCOs and other health plans to facilitate the eventual transition of all individuals, including exchange enrollees, Medicare beneficiaries, and state employees, into high value care models
- Collects statewide claims data through the state's all payer, all claims database to evaluate the success of care delivery models and inform future policy

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[i] Michigan Association of Health Plans. Performance, Value, Outcomes: Medicaid Managed Care: FY 2011-2013. June 2011.
[ii] Douglas McCarthy and Kimberly Mueller. Community Care of North Carolina: Building Community Systems of Care through State and Local Partnerships. Commonwealth Fund Publication 1219 Vol. 8, June 2009.
[iii] Ibid
[iv] Oregon Policy Board. Coordinated Care Organizations. Available at http://www.oregon.gov/oha/ohpb/pages/health-reform/ccos.aspx
[v] Oregon Health Authority. News and Information. Oregon Governor John Kitzhaber Announces How Federal Dollars Will Help Coordinated Care Organizations [vv] Give Better Health Care At Lower Costs. Available at: www.oregon.gov/oha/news/Pages/OregonGovernorJohnKitzhaberannounceshowfederaldollarswillhelp CoordinatedCareOrganizationsgivebetterhealthca.aspx

TRINITY ⬤ HEALTH
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